Dr. Cathleen MacDonald, BScN, N.D
6156 Quinpool Road, Suite 201 Halifax, NS B3L 1A3
info@cathleenmacdonald.ca 902-452-2070

ADULT INTAKE FORM

Please note that all information disclosed is confidential and will not be released without your permission.

DATE**:** _____

Name: _____ Date of Birth: __/__/___
Last, First d m y

Address:

_____
Street City Province Postal Code

Telephone Home: (___) _____Work Phone: (___) _____ Mobile: (___) _____

Email: _____ Your preference for method of contact? _____

Would you like to receive email reminders about your future appointments? _____

Emergency Contact:

Name _____ Relationship _____ Phone (___)_____

How did you hear about this office? _____

HEALTH CONCERNS IN ORDER OF IMPORTANCE TO YOU:

CONCERN	SINCE	CAUSES

GENERAL STATE OF HEALTH AS: (good, fair, poor)

Child _____

Adolescent _____

Adult _____

PLEASE CIRCLE ANY CONDITIONS THAT YOU HAVE HAD.

Heart Disease	Thyroid Disease	Diabetes	Sexual Abuse	Asthma
High Blood Pressure	STI's Cancer	Kidney Disease	Epilepsy	Sinusitis
Blood Diseases	Acute Rheumatoid	Arthritis	Tuberculosis	Hay Fever
Alcoholism	Stroke	Hepatitis	Cold Sores	Allergies
Psychiatric Disorders	Familial Disorders	Gall Stones	Herpes	Mononucleosis
Depression	Gout	Rubella	Diphtheria	Polio
Scarlet Fever	Measles	Mumps	Chicken Pox	Whooping Cough

IMMUNIZATIONS

Have you had childhood vaccines? _____ Do you get the flu vaccine? _____

Have you had any unusual reactions to vaccinations? _____
_____

LIST ANY ACCIDENTS, INJURIES OR HOSPITALIZATIONS _____

_____

PLEASE CIRCLE THE FOLLOWING CONDITIONS THAT HAVE AFFECTED YOUR RELATIVES (i.e. children, siblings, parents, grandparents).

Liver disease Heart disease Psychiatric Disorders High Blood Pressure	Respiratory Asthma Allergies Tuberculosis Autoimmune	Thyroid Alzheimer's Osteoporosis Stroke Arthritis	Blood Diseases Cancer Kidney disease Diabetes Bowel disease

CURRENT HEALTH HISTORY: (Circle and date of most recent)

SCREENING TESTS:

Pap smear
Breast exam
Mammogram
Colonoscopy
Bone density
Prostate exam

ALLERGIES: Medications: _____
Food: _____
Environment: _____
Other: _____

DIET
Diet Restrictions: _____

Intolerances: _____

Any symptoms experienced after eating: _____
_____

Recent Weight Gain or Loss? _____

Environmental Hazards? At Home _____ At Work _____

MEDICATIONS and SUPPLEMENTS:
MEDICATIONS: Current use: _____
_____

Over the counter medications: _____

Supplements, Herbal remedies and Homeopathic remedies: _____
_____

Tobacco, Alcohol, Caffeine: _____

Recreational Drug use: _____

EXERCISE AND LEISURE ACTIVITIES: _____
_____

SLEEP PATTERN:
1. Hours per night _____
2. Quality: Excellent ( ), Good ( ), Fair ( ), Poor ( )

PERSONAL / SOCIAL HISTORY
(Occupation, family structure and relationships, stresses and outlook on life)
_____

ARE YOU CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN OR HEALTH CARE PRACTITIONER(S)?

Physician/Health Care Practitioner	For what condition?	Treatment(s)

Consent Form

In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of acknowledgement. In doing so you understand that:

- You are at liberty to seek or continue medical care from a physician or surgeon or other healthcare provider.
- Cathleen MacDonald ND is not suggesting or recommending that you refrain from seeking or following the advice of another licensed healthcare provider.
- The treatment and therapies rendered or recommended by this office may be different than those usually offered by a medical doctor or other licensed healthcare provider.
- The ultimate responsibility for your health care is your own, and Cathleen MacDonald, ND is here to support you in this.
- While changes in dietary habits are not an absolute pre-requisite for treatment, failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results.
- If any explanation of proposed treatment or therapy is not clearly understood, you are responsible to seek clarification.
- All information you give regarding your health history is true to the best of your knowledge.
- The office privacy policy is available on the website and on the bulletin board at the office.
- Payment is made either by cash, debit, cheque visa or mastercard at the time of the visit.
    - The initial consultation is 60 – 90 minutes and is $165
    - Subsequent consultations are 30-45 minutes and are $85
    - $50 fee for NSF cheques.
    - Phone consultations are rounded to the nearest 15 minutes and based on $165/hour
- Notice of 24 hours is required for appointment cancellation.

I have read, understood and acknowledged the above consent to treatment. I hereby authorize and consent to naturopathic treatment by Cathleen MacDonald, N.D.

_____ _____

Signed Date